THE MARYLAND HEALTH CARE COMMISSION

FY 2005 BUDGET

PRESENTATION TO THE LEGISLATURE

M00R0101
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Department of Health and Mental Hygiene

MARYLAND HEALTH CARE COMMISSION
BUDGET PRESENTATION

I. OVERVIEW

The mission of the Maryland Health Care Commission is to plan for health systems needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers, and the public.

Our vision is a state in which informed consumers hold the health care system accountable, and have access to affordable and appropriate health care services through programs that serve as national models.

II. DETAILS – MAJOR ACCOMPLISHMENTS

A major focus of the Commission's work is the provision of accurate and timely information to consumers and other purchasers of health care services. The Commission introduced a new reporting system for ambulatory surgical services, as well as revised reporting systems for nursing homes, hospitals, HMO and Point of Service (POS) plans during the last fiscal year.

During FY 2003, the Commission released the sixth series of annual HMO reports. In the fall of 2002, the first three publications: *The 2002 Consumer Guide to Maryland HMOs & POS Plans* (often referred to as the "HMO Report Card"); *The 2002 Guide to Maryland HMOs & POS Plans for State Employees;* and the *Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland,* were completed and released. At the same time, an interactive web-based version of the *Consumer Guide* was posted on the Commission's website, as well as PDF versions of the first three publications of the annual four report series. In January 2003, the *Policy Report on Maryland Commercial HMOs & POS Plans* was released, completing the 2002 series of HMO reports. Hard copy circulation in 2003 was 37,000 Consumer Guides, 60,000 copies of the State Employees Guide, 1,000 copies of the Comprehensive Report, and 800 Policy Reports.

The Commission also continues regularly to update the web-based *Maryland Nursing Home Performance Evaluation Guide.* The guide offers a detailed look at over 200 comprehensive-care nursing facilities and continuing care retirement communities. The guide enables consumers to review information on facility and residential characteristics, Quality Indicators, and any deficiencies observed during the state inspection of the nursing home. In addition, the Guide also provides general information about nursing homes to consumers.

The Commission participated in the CMS pilot program with five other states from April through early November 2002. At the conclusion of the pilot, CMS conducted a national rollout of the CMS Nursing Home Quality Initiative on November 1, 2002. The Commission's website was subsequently updated in January 2003 to reflect the final CMS Nursing Home Quality measures. Seven of the ten quality measures reported on the CMS website are featured on the Maryland Guide in a more user-friendly format. In 2003, there were over 52,000 web visits to this Nursing Home Guide.

A new addition of the *Hospital Performance Evaluation Guide* was released in May 2003 and for the first time included quality of care measures. The quality of care information is specific to the treatment and prevention of congestive heart failure and community acquired pneumonia, such as individual hospital rates, the state average, and the highest rate achieved by a hospital in Maryland for each of the measures. The guide continues to enable consumers to review information on several facility characteristics, such as location of the hospital, number of beds, and accreditation status. General information is also included on patient rights, how hospitals are regulated in Maryland, a checklist to help consumers pick a hospital, and guidance on what to expect in a hospital setting. The Guide is available on the Commission's website. In 2003, there were over 53,000 web site visits.

The Commission is also responsible for the development of a performance report for *Ambulatory Surgical Facilities* (*ASF*). A web-based report was released by the Commission in May 2003. The web-site contains structural (descriptive) facility information including the jurisdiction, accreditation status, and the number and type of procedures performed in the past year. The site also includes several consumer resources.

One of the highlights for the fiscal year was the Commission's work related to Patient Safety. The *Final Report on the Study of Patient Safety in Maryland* was approved by the Commission and submitted to the members of the Maryland General Assembly in January 2003. The Maryland Patient Safety Steering Committee continues to meet regularly. The role of the Coalition is undergoing redefinition to focus on specific goals, such as education and advocacy. In addition, the Commission staff has prepared a request for proposal (RFP) to designate the Maryland Patient Safety Center to be operational during FY 2004.

Senate Bill 479, enacted by the General Assembly in 2003, established the Maryland Trauma System Funding Act. Commission staff has begun the implementation and administration of the trauma fund. Planning meetings were held with the Medicaid Administration and the Motor Vehicle Administration regarding implementation issues. A coordination meeting was also held with staff from the Maryland Institute for Emergency Medical Services (MIEMMS).The MHCC, Health Services Cost Review Commission (HSCRC), and the Administrative, Executive and Legislative Review Committee (AELR) approved COMAR 10.25.10, Trauma Physicians Fund for promulgation in August 2003, and was approved for final action at the November 20, 2003 MHCC Commission Meeting. It is estimated that approximately $7 million will be paid out for reimbursement of uncompensated trauma care from this fund during FY 2004, and $10 million dollars in FY 2005.

In January 2004, the Commission released the *Annual Report on State Health Care Expenditure: Experience from 2002.* The report monitors the performance of the state's health care system by reporting the level and growth rate of health care spending. Total health care spending for Maryland residents increased to $22.6 billion from $20.4 billion in 2001. The 11 percent rate of growth in 2002 was 1 percentage point lower than the growth rate MHCC reported for 2001. The modest decline is consistent with recent national analyses that show slowed spending in 2002.

The Commission, in March 2003, released the *Practitioner Utilization: Trends within Privately Insured Patients, 2000 – 2001* report. The report examines how payments to physicians and other health care practitioners for care of the privately insured Maryland residents under age 65 changed from 2000 to 2001, including Medicare reimbursement rates. From the data collected, it was found that health care spending increased by double digits from 2000 to 2001. The purpose of the analysis was to provide explanations for the increased

expenditures for practitioner services, in particular. The analysis found that spending for these services grew by 10 percent due to greater utilization and the higher cost of more complex care.

Payer and practitioner interest in adopting and expanding the use of Electronic Data Interchange (EDI) continued to gain momentum during this past fiscal year. The staff developed a series of education and awareness tools aimed at increasing practitioner and health care facility staff members' understanding of the efficiencies that EDI generates. The 2003 EDI-HIPAA Progress Report, released in December 2003, indicates that even though growth in electronic claims has slowed as the industry responds to HIPAA, EDI use among Government and private payers continues to increase. Today, 60% of claims in Maryland are processed electronically, up from 53% in 2000.

Many practitioners and health care institutions have relied on the Commission for accurate information regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Administrative Simplification requirements. Staff provided industry awareness training on HIPAA to various medical, non-medical, and institutional providers. Regional medical group manager associations and allied health associations routinely invited staff to their organizations to conduct various EDI-HIPAA education and awareness programs. The EDI Focus Group provided staff with feedback relating to several of its EDI-HIPAA initiatives. The Maryland Health Care Commission conducted 60 seminars and training sessions during FY 2003.

Throughout FY 2003, the Commission accomplished several goals relating to the Comprehensive Standard Health Benefit Plan (CSHBP). The Commission finalized regulations implementing benefit changes to the CSHBP during the annual review. In June 2003, Commission staff presented the results of the annual financial survey of carriers participating in the small group market entitled *Summary of Carrier Experience for Calendar Year Ended December 31, 2002*. The CSHBP now impacts more the forty-five percent of the small employers in the state (52,650) and covers more than 445,000 lives. Also, since the passage of small group market reforms, the number of small employers offering coverage has increased 20% and the number of covered lives has increased 11%. Other results include: (1) CSHBP premium is within the affordability cap; (2) increases in CSHBP premium (11.8%) are comparable to, if not less than, increases in small group markets elsewhere (13%); and (3) there is still a choice of carriers, but domination by major carriers continues to grow.

In the 2003 Legislative Session, the average premium cap was set not to exceed 10 percent of the average annual wage. To maintain the cap into FY 2004, there will need to be a thorough review of benefits and out of pocket costs for the CSHBP.

During the 2003 Legislative Session, the process in which the Commission studies mandated benefits was revised. Formerly, if the 2.2% affordability cap was exceeded, an analysis of the financial, medical and social impacts of all current mandates was required. The new study requires the Commission to include: (1) an assessment of the full cost of each existing mandated benefit as a percentage of the state's average annual wage and of premiums for the individual and group health insurance market; (2) an assessment of the degree to which existing mandated benefits are covered in self-funded plans; and (3) a comparison of mandated benefits provided by a state with those provided in Delaware, the District of Columbia, Pennsylvania, and Virginia. The Commission presented to the General Assembly a report entitled *Mandated Health Insurance Services Evaluation, December 31, 2002.* The report contains actuarial estimates of the annual cost impact of Maryland's existing required

health insurance services for group insurance plans, individual insurance plans, the CSHBP for small groups, and the Maryland state employee benefit plan. The report also includes updates on the estimated costs of the existing mandates in order to monitor the statutory cap of 2.2% of Maryland's average annual wage. The cap now stands at just under 2.1% of the average annual wage.

The Commission, in collaboration with DHMH and the Johns Hopkins School of Public Health, was awarded a $1.2 million State Planning Grant by the Health Resources Services Administration (HRSA). HRSA is the federal agency that oversees programs to ensure access to care and improve quality of care for vulnerable populations. The two-year federal grant provides Maryland with substantial resources to examine the State's uninsured population and the employer-based insurance market and to develop policy options to make comprehensive health insurance coverage fully accessible to all Marylanders. The Commission released, in December 2003, *Health Insurance Coverage in Maryland: Through* 2002. This report is also available through a link on the Commission's website. A final report is due to the Secretary of the Department of Health and Human Services in July 2004, outlining an action plan to continue improving access to insurance coverage in Maryland.

The Commission recognizes the need to evaluate emerging trends in cardiac services. Therefore, the State Health Plan for Facilities and Services: Specialized Health Care Services-Cardiac Surgery and Therapeutic Catheterization Services (COMAR 10.24.17) is undergoing amendment for the third time in six years. In June 2003, the Commission began updating the State Health Plan to reflect the findings and recommendations of the Advisory Committee on Outcome Assessment in Cardiovascular Care on interventional cardiology services. The Commission released in June 2003, the Final Report on Interventional Cardiology. Final recommendations of the Advisory Committee on additional issues, including quality measurement and data reporting, inter-hospital transport, and long-term issues will be presented to the Commission in early 2004.

During FY 2003, there were thirty Certificate of Need actions and the Commission staff reviewed a total of 152 requests for determination of coverage by CON requirements, including four requests by CON holders for "pre-licensure certification," confirming that the new health care facilities conform to the project as approved by the Commission. Of the 152 requests for a determination of whether Certificate of Need review was required, only three of the actions proposed by health care facilities or providers were found to require Certificate of Need review and approval, and one proposal was determined to require a Commission action on an exemption from Certificate of Need.

During the reporting period, the Commission also studied emerging trends with post-acute services, updated utilization projections for organ transplant and obstetric services, and initiated an update of the State Health Plan for the Acute Inpatient Services (COMAR 10.24.10). At the December 2003 Commission meeting, COMAR 10.24.10 was approved by the Commission as proposed permanent regulation.

III. BUDGET

The Commission's FY 2005 budget request is $18,629,448, which includes $10 million requested for the Maryland Trauma Physicians Fund. The budget request is for the continued funding for routine operation expenses, appropriation for 66.0 permanent staff and 2.0 contractual staff, on-going mandates such as the release of the *Consumer Guide to Maryland*

HMOs & POS Plans, the *Maryland Nursing Home Performance Guide*, the *Hospital Performance Guide*, a performance report for *Ambulatory Surgical Facilities*, updating the State Health Plan for Facilities and Services, and the Trauma Fund.

The Commission will be embarking on a two-year reduction plan to reduce its current surplus in revenues. At the close of FY 2003, the Commission has a surplus of $3,053,741. The existing surplus has developed over the past few years due to: 1) cost containment measures implemented by the Department of Budget and Management; 2) measures initiated by Commission itself to achieve prudent spending patterns; and 3) an overage in assessment for the Health Occupational Boards.

Historically, the Commission has been diligent in returning any surplus over the allowable 10% of its budget, set by Sunset Review. It is the intent of the Commission to begin the reduction plan in FY 2005 and continue it through FY 2006, for those on a bi-annual renewal cycle. The reduction will be approximately $2 million dollars for all payers.

The Commission feels that it is of the highest priority, when necessary; to immediately implement a plan to return any unused assessment to the payees in direct proportion to their contribution. This reduction plan will achieve this goal.

Department of Health and Mental Hygiene
Maryland Health Care Commission
M00R0101

Response to Issues

Issue:

Legislation Establishes Maryland Trauma Physicians Fund

Response:

So far, no unexpected issues. The fund, for accounting purposes, has been set up. Regulations were made final in December with emergency regulations that were already in place. The Commission has held several meeting with physician groups to go over the process, and we anticipate that the first disbursement will be made after May 1st. Applications will be accepted and audited during the month of April, 2004.

Issue:

Fund Balances Exceeds Targeted Levels

Response:

The Maryland Health Care Commission's current surplus has developed over the last three fiscal years for the following reasons:

I. Cost Containment measures issued by the Department of Budget and Management

II. Cost Containment measures initiated by the Commission itself within programmatic areas to achieve prudent spending patterns and align budgetary spending with MFR goals

III. Overage in Assessment for the Health Occupational Boards

The Commission has put into place a 2-Year reduction plan for FY 2005 and FY 2006 to reduce the current surplus in revenues by $2.2 million. A copy of this plan has been submitted with your Budget Presentation.

Department of Health and Mental Hygiene
Maryland Health Care Commission
M00R0101

Response to Recommended Actions

Recommendation:

Reduce funding for position reclassifications

Response:

The Maryland Health Care Commission accepts the recommendation of the Legislative Analyst to reduce funding for position reclassifications in the Fiscal Year 2005 budget request. However, the Commission's request a breakout per Commission of the remaining amount allocated.

THE HEALTH SERVICES COST REVIEW COMMISSION

FY 2005 BUDGET

PRESENTATION TO THE LEGISLATURE

MOOR0102
Robert B. Murray
Executive Director, HSCRC

Department of Health and Mental Hygiene

HEALTH SERVICES COST REVIEW COMMISSION - FY 2005 BUDGET PRESENTATION

I. OVERVIEW

The Health Services Cost Review Commission (the "HSCRC" or "Commission") was established in 1971 with two principal responsibilities: to publicly disclose hospital financial data and trustee relationships, and to set hospital rates.[1] Under Maryland's unique "All-Payor" system , all payors, including Medicare and Medicaid, pay hospitals on the basis of the rates established by the Commission. This system is made possible by the state's Medicare Waiver that was negotiated in 1977. To retain this waiver, Maryland must pass a quarterly financial test, administered by the Medicare agency.

Under the Medicare waiver, the Center for Medicare and Medicaid Services (CMS) agreed to waive federal reimbursement policy and instead pay hospitals in Maryland on the basis of rates set by the HSCRC. In order to maintain our waiver, we must pass a quarterly test that compares Maryland's rate of increase from a base, for Medicare payments per admission, to that of the rest of the nation. The test requires that Maryland Medicare payment per case grow more slowly than U.S. Medicare payment per case from 1980 to the current period.

In the mid- to late- 1990s, with large reductions in Medicare payments nationally, Maryland's cushion on the waiver test eroded significantly. In response to this circumstance, the HSCRC substantially "redesigned" the rate system to allow for greater control over year to year growth of net payments to hospitals (including Medicare payments). Since 1999, our Medicare waiver cushion has improved from a relative cushion of 8.8% to the current 15% level.[2] This cushion is expected to erode (by design) over the period FY 2004-2006 to 11% given the HSCRC's decision to improve hospital profitability and facilitate needed recapitalization efforts.

While the Commission's rate review function is largely to constrain annual hospital rate increases and promote hospital efficiency, the payment system was also designed to achieve the following important objectives: 1) to provide universal financial access for hospital care; 2) to set fair rates for all payors and thereby prohibit cost-shifting; 3) to make all parties accountable to the public, and 4) to maintain solvency for efficient and effective hospitals. The results achieved have fulfilled the legislature's original objectives:

[1] The Commission consists of seven members appointed to four-year terms by the Governor and is staffed by 27 full-time positions. The Commission regulates and industry of 47 acute care hospitals, five private psychiatric hospitals, and three chronic care hospitals, with system revenues in excess of $8 billion.

[2] The "relative" cushion shows how much more Maryland Medicare payment per case could grow (assuming Medicare were to freeze payment increases to hospitals nationally - so no growth in Medicare payment per case nationally) before Maryland failed the waiver test.

Cost Containment: Maryland achieved the lowest absolute growth in hospital costs in the nation over the period 1976 to 1992. In the period 1992-2000, hospital costs nationally slowed dramatically due to the pressures of Managed Care. During this period Maryland's position vis a vis the nation on the basis of hospital cost per admission eroded from a position of 12% BELOW the U.S. to 2% ABOVE the U.S. (i.e., hospital costs nationally grew much more slowly than hospital costs in Maryland during this period). Since that time, with the Rate Redesign efforts instituted by the Commission in FY 2001 the system is once again BELOW U.S. Hospitals' cost per admission.[3] This recent performance returned Maryland to a position of experience the lowest absolute rate of growth of hospital costs of any state over the 1976 - 2003.

Equity: From the patient's perspective, Maryland has the fairest hospital payment system in the country by far. There is virtually no cost shifting. Maryland hospitals have the lowest "markup" of charges over cost in the nation (approximately 17%). As a result, the private sector (largely the business community) faces substantially reduced hospital costs for its employees relative to what is experienced in other states where hospitals routinely shift costs to the private sector by marking up charges 100-200% over cost. Individual patients also benefit from our lower markups by way of lower co-pays. Finally, amounts charged by hospitals to uninsured patients are also substantially below amounts charged to uninsured patients outside of Maryland because of our lower markups.

Access to Care: Because of the rate system, all Maryland citizens have financial access to needed hospital services and Maryland has no public hospitals, while in other states public hospitals tend to be the primary source of care for indigent patients.

Financial Stability: The Maryland Hospital system, by all accounts provides a far more predictable and stable financial environment for hospitals. Solvency has been maintained for efficient institutions, and our hospitals have retained or enhanced their reputations for clinical and teaching excellence.

II. BACKGROUND

Recent Major Accomplishments

1. Cost Containment Activities

As previously discussed, the system has improved on the Medicare waiver from an 8.8% relative cushion in 1999 to a 15% relative cushion in FY 2002. The system also improved its position versus hospital's nationally on the basis of Cost/Admission, moving from 2% ABOVE the U.S. in 1998 to an estimated position of 6% BELOW the U.S. as of FY 2003.

2. Financing of Uncompensated Care

The rate setting system continues to embody a provision in its rates for care to the indigent, financing approximately $450 million of hospital uncompensated care in FY 2003. This feature of the system continues to be one of the most beneficial and unique aspects of the rate-setting system here in Maryland. As a result, we have avoided the fiscal and health crises faced by other states in attempting to provide for care to the indigent through a taxpayer-financed public hospital systems. In an attempt to further bolster this system, in FY 1998 the Commission implemented the Uncompensated Care Fund.

[3] Maryland is estimated to be more than 6% BELOW the US on hospital cost per adjusted admission as of FY 2003.

This fund was created by an assessment on all hospital rates and was designed to spread the cost of financing uncompensated care more equitably.

As discussed later in this write-up this system proves to be resilient in periods of budgetary crises. Earlier in FY 04, the HSCRC modified its Hospital UC funding methodology to make the hospitals "whole" on a current or "real time" basis for the reductions in Medicaid funding through the imposition of day limits.

3. Quality of Care Initiative

The HSCRC is working to build on the efforts of the Maryland Health Care Commission's Hospital Report Card, by implementing a system of rewards and incentives to stimulate broad improvements in hospital quality of care and reduction in medical errors. The Commission recently approved a staff work plan for this effort.

The Commission's FY 2005 current Operating Budget request is $3,443,986 for the administration of the agency and $56,000,000 for the Uncompensated Care Fund. These items will be funded through the HSCRC special fund. The administrative request will fund 27.6 full-time positions, consultant contracts for data processing services, actuary assistance, audits of case-mix and financial data, payment system redesign, and routine operating costs.

Department of Health and Mental Hygiene
Health Services Cost Review Commission
M00R0102

Response to Issues

Issue:

Fund Balances Exceed Targeted Levels: Fund balances in the Health Regulatory Commissions indicate that user fee assessments exceed the actual cost of operations. Despite efforts to reduce the amount of surplus, each of the commissions continues to exceed recommended fund balance levels.

Response:

The HSCRC has been trying to implement measures in order to spenddown its current carryover/surplus over the past few years. Unfortunately, the State's cost containment measures (PIN cuts and hiring freeze) in combination with the user fees previously assessed to Maryland hospitals (based on approved budget appropriation at the beginning of the fiscal year), has resulted in the carryover/surplus to be higher than originally projected. Stated another way, the budget cuts were implemented after the user fee billing for the current fiscal year was sent to the hospitals for payment. If the proposed assessment of indirect cost is approved for Fiscal Year 2005, the HSCRC will pay the indirect cost amount largely out of the HSCRC carryover/surplus. If the proposed assessment of indirect cost is not approved for Fiscal Year 2005, the HSCRC will take a 10% reduction in the collection of user fees to reduce the carry over/surplus.

Department of Health and Mental Hygiene
Health Services Cost Review Commission
M00R0102

Response to Issues

Issue:

Cost Containment Shifts Costs to Hospital Payors: Recent cost containment efforts have shifted some of the cost of providing care for the uninsured to the uncompensated care system. Several measures rely on the rate setting system to compensate for service reductions, shifting the cost of providing services to the uninsured from the general fund to hospital payors.

Response:

The recent cost containment activities have indeed resulted in reduced direct funding of health care coverage and payment for health care services to Medicaid enrollees and the so-called "Grey-zone" population (low income individuals who do not meet the Medicaid income eligibility requirements but are otherwise considered to be the :"working poor"). These actions will result in increased levels of Hospital Uncompensated Care, that will be funded through Hospital rates paid by all payors (including Medicare, Medicaid and Commercial payors).

The largest of these cost containment activities were manifested through the imposition of day limits on Medicaid payments for the Fee for Service (FFS) Medicaid population. This cut is a "one-time" cut spanning an 18-month period and is scheduled to expire June 30, 2005. The other cuts (the elimination of proxy bed payments, possible privatization of the Walter P. Carter Center and elimination of funding for payment for mental health hospital outpatient treatment for the "Grey-zone" population - not discussed by the analyst) are permanent cuts that will result in higher levels of hospital uncompensated care over the long term. The distinction between "one-time" versus "permanent" cuts are important in terms of the impact of these actions on payors and for our performance on the Maryland Medicare Waiver.

The "one-time cuts" associated with the imposition of day limits will result in erosion of our Waiver cushion on a one-time basis. However this erosion will be reversed when the cuts expire FY 2006. The "permanent cuts" will result in a permanent erosion of our position on the Medicare waiver test. The following summarizes the approximate dollar magnitudes of these cost containment activities:

Category	Type of Cut	Approx. $ amt.	% Rev
1) Medicaid Day Limit Imposition	One-time Cut	$50 million	0.63%
2) Proxy Bed payment elimination	Permanent Cut	$ 4 million	
3) Possible Privatization of Carter Center	Permanent Cut	$15 million	
4) Elimination of Grey-zone payments	Permanent Cut	$ 3 million	
Subtotal potential impact of Permanent Cuts		$22 million	%0.28

Our current cushion on the Medicare Waiver is around 15%. This cushion is expected to erode

(independent of these cost containment impacts) to around 11% by FY 2006. While any circumstance that results in an erosion of the Waiver test is of concern, it is the conclusion of HSCRC that the 0.28% impact of the permanent cuts will not put our Waiver at risk.

Department of Health and Mental Hygiene
Health Services Cost Review Commission
M00R0102

Response to Recommended Action

Recommendation:

Reduce funding for positions reclassifications. Total Reductions - $49,128.

Response:

As the total amount of fund reduction includes both the Health Services Cost Review Commission and the Maryland Health Care Commission, the Health Services Cost Review Commission requests a breakdown of the actual reduction for each of the Commissions prior to the acceptance of this recommendation.